Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Clear Vue Laser Eye Center, Inc.
Docket No. A-18-49
Decision No. 2957
July 26, 2019

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Clear Vue Laser Eye Center, Inc. (Clear Vue or Petitioner) appeals an Administrative Law Judge (ALJ) decision upholding on summary judgment the Centers for Medicare & Medicaid Services' (CMS) determination to revoke its Medicare enrollment and billing privileges under 42 C.F.R. § 424.535(a)(8). *Clear Vue Laser Eye Center, Inc.*, DAB CR5016 (2018) (ALJ Decision). The ALJ concluded that the revocation was authorized under that regulation because Petitioner had abused its billing privileges by submitting claims for Medicare reimbursement for services putatively performed by its owner, Monique Barbour, M.D., but which she could not have provided on the claimed service dates.[1] For the reasons stated below, we affirm the ALJ Decision.

Relevant Authorities

The Social Security Act (Act)[2] provides for CMS to regulate the enrollment of providers and suppliers in the Medicare program. Act § 1866(j)(1)(A) (42 U.S.C. § 1395cc(j)(1)(A)). The implementing regulations appear in 42 C.F.R. Part 424, subpart P. Among the applicable provisions, section 424.535(a)[3] provides reasons for which enrollment may be revoked, including the following:

---

[1] The ALJ simultaneously issued a decision upholding the revocation of Dr. Barbour's Medicare enrollment and billing privileges. *See Monique Barbour, M.D.*, DAB CR5015. We address Dr. Barbour's appeal of that ALJ Decision separately in DAB No. 2957, released concurrently with this decision.

[2] The current version of the Social Security Act can be found at https://www.ssa.gov/OP_Home/ssact/ssact-toc.htm. (Last visited July 18, 2019.) Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at https://www.ssa.gov/OP_Home/comp2/G-APP-H.html. (Last visited July 18, 2019.)

[3] This section was substantially revised effective February 3, 2015. 79 Fed. Reg. 72,500, 72,532 (Dec. 5, 2014). We apply the regulation as in effect at the time of the revocation (June 24, 2015). *See, e.g., John P. McDonough III, Ph.D., et al.*, DAB No. 2728, at 2 n.1 (2016).

(8) *Abuse of billing privileges.* Abuse of billing privileges includes either of the following:

(i) The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to the following situations:

*   *   *

(B) The directing physician or beneficiary is not in the state or country when services were furnished.

The Act also provides, in pertinent part:

> [P]ayment may be made to a physician for physicians' services [. . .] furnished by a second physician to patients of the first physician if . . . (iv) the claim form submitted to the carrier for such services includes the second physician's unique identifier (provided under the system established under subsection (r) and indicates that the claim meets the requirements of this subparagraph for payment to the first physician.

Act § 1842(b)(6)(D)(iv). Subsection (r) provides:

> The Secretary shall establish a system which provides for a unique identifier for each physician who furnishes services for which payment may be made under this title.

CMS publishes the Medicare Claims Processing Manual (MCPM), CMS Pub. 100-04,[4] which describes policy applicable to Medicare fee-for-service claims, that is, claims filed under the original or traditional Medicare program. MCPM Ch. 23, § 20. The instructions in the MCPM apply to providers and suppliers, and to CMS's contractors (such as First Coast Service Options, Inc. (First Coast)) that process their claims. *Id.* The MCPM explains that CMS uses the Healthcare Common Procedure Coding System (HCPCS), as the approved coding set for entities covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for reporting outpatient procedures. HCPCS is based on the American Medical Association's (AMA) "Physicians' Current Procedural Terminology, Fourth Edition" (CPT-4). *Id.* It includes three levels of codes and modifiers. *Id.* Relevant to this appeal, Level II contains alpha-numeric codes primarily for items and non-physician services not included in CPT-4, e.g., ambulance, durable medical equipment (DME), orthotics and prosthetics. *Id.* Level II codes are

[4] The MCPM and other CMS manuals are available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html. (Last visited July 18, 2019.)

normally updated annually but may be issued quarterly to provide new or changed Medicare coverage policy for physicians' services as well as services normally described in Level II.[5] *Id*.

The preamble to the final rule originally promulgating section 424.535(a)(8)[6] states:

> This revocation authority is not intended to be used for isolated occurrences or accidental billing errors. Rather, this basis for revocation is directed at providers and suppliers who are engaging in a pattern of improper billing . . . . We believe that it is both appropriate and necessary that we have the ability to revoke billing privileges when services could not have been furnished by a provider or supplier. We recognize the impact that this revocation has, and a revocation will not be issued unless sufficient evidence demonstrates abusive billing patterns. Accordingly, *we will not revoke billing privileges under § 424.535(a)(8) unless there are multiple instances, at least three, where abusive billing practices have taken place*. . . . . In conclusion, we believe that providers and suppliers are responsible for the claims they submit or the claims submitted on their behalf. We believe that it is essential that providers and suppliers take the necessary steps to ensure they are billing appropriately for services furnished to Medicare beneficiaries.

73 Fed. Reg. 36, 448, 36,455 (June 27, 2008) (emphasis added).

Revocation results in the termination of the provider's or supplier's agreement with Medicare as well as a bar on re-enrollment from one to three years, depending on the severity of the basis for revocation. 42 C.F.R. § 424.535(b)-(c).

---

[5] Series "Q," "K," and "G" in the Level II coding are reserved for CMS assignment. "Q," "K," and "G" codes are temporary national codes for items or services requiring uniform national coding between one year's update and the next. Sometimes "temporary" codes remain for more than one update. MCPM Ch. 23, § 20.3.

[6] The original section 424.535(a)(8) read as follows:

> (8) *Abuse of billing privileges.* The provider or supplier submits a claim or claims for services that could not have been furnished to a specific individual on the date of service. These instances include but are not limited to situations where the beneficiary is deceased, the directing physician or beneficiary is not in the State or country when services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred.

Factual and procedural background[7]

On June 24, 2015, First Coast revoked Petitioner's Medicare enrollment and billing privileges based on 42 C.F.R. § 424.535(a)(8). CMS Ex. 3. At that time, Petitioner, an ophthalmologist's group medical practice, participated as a supplier in the Medicare program.[8] CMS Ex. 2, at 1-2. The initial determination letter stated that data analysis revealed that from July 13, 2009 to March 30, 2015, Petitioner submitted "claims for services purportedly rendered to beneficiaries by Dr. Monique Barbour on dates Dr. Barbour was outside of the United States. See Attachment A." CMS Ex. 3, at 1. Attachment A to the notice of revocation comprised several charts reflecting "[c]laims submitted by Clear Vue Laser Eye Center as billing provider for services purportedly rendered by Dr. Monique Barbour on dates of service she was outside of the United States." *Id.* at 3. The documented periods of travel outside the United States listed in the letter occurred between July 13, 2009 and March 30, 2015. *Id.* at 1. The letter also notified Petitioner that CMS was imposing a three-year re-enrollment bar. *Id.* at 2.

Petitioner sought reconsideration of the initial determination. CMS Ex. 2. Petitioner asserted that First Coast's revocation denied Petitioner due process because it did not comply with the regulations and did not afford Petitioner reasonable notice and the opportunity to be heard as to which subsection of section 424.535(a)(8) was the basis for revocation. *Id.* at 3. Nonetheless, Petitioner noted that the revocation notice specified that data analysis of Petitioner's claims during the specified period revealed claims for services purportedly furnished by Dr. Barbour to beneficiaries on dates when Dr. Barbour was outside the United States. *See id.* at 4. Further, Petitioner conceded that a substitute physician performed some services for Medicare beneficiaries while Dr. Barbour was out of the country, and that Petitioner had failed to use the correct modifier, Q6, on the claim forms submitted seeking payment for those services. *See id.* Petitioner also represented that a technician employed by Clear Vue performed certain testing services under Dr. Barbour's general supervision and that the regulation at 42 C.F.R. § 410.32 did not require Dr. Barbour to be present when testing was conducted. *Id.* at 5. Next, Petitioner argued that Dr. Barbour was in fact in the country on dates of service related to three claims and that the Q6 modifier was inadvertently omitted and certain dates of service were entered incorrectly by billing personnel. *Id.* First Coast was incorrect, Petitioner argued, when it determined that Petitioner submitted claims for services which "could not have been provided" because those services were in fact furnished to beneficiaries by substitute personnel. *Id.* Petitioner further argued that the regulations required CMS, and

[7] Unless otherwise indicated, the facts stated in this section reflect the findings in the ALJ Decision or are undisputed facts based on the evidence of record.

[8] The regulations define "supplier" to mean "a physician or other practitioner, or an entity other than a provider, that furnishes health care services under Medicare." 42 C.F.R. § 400.202.

not First Coast, to determine that a supplier had engaged in a pattern of abusive billing. *Id*. at 6. Citing the preamble to the final rule promulgating section 424.535(a)(8), Petitioner contended that CMS did not intend to invoke its revocation authority for inadvertent coding and billing errors and that CMS intended for section 424.535(a)(8) to apply to situations where payment of claims was denied, not where claims were paid – and that Petitioner's claims had been paid. *Id*. Petitioner also requested reconsideration of the three-year re-enrollment bar, arguing that its imposition was arbitrary and capricious. *Id*. at 10.

By letter dated October 19, 2015, CMS denied Petitioner's request for reconsideration, concurring with the initial determination and stating that Dr. Barbour "submitted claims to the Medicare program for payment for services that could not have been furnished to specific individuals on dates of services because Dr. Barbour was out of the country from July 13, 2009 to March 30, 2015." CMS Ex. 1, at 2. The letter further stated that Dr. Barbour "has a practice of submitting claims that fail to meet Medicare requirements, due to failure to use modifier Q6 for locum tenens services and allowing technicians to perform testing without the appropriate level of supervision." *Id*. at 3. Petitioner then requested an ALJ hearing.

The ALJ Decision

The parties filed cross-motions for summary judgment. The ALJ concluded that CMS was entitled to summary judgment in its favor because the undisputed evidence established that Dr. Barbour was out of the country and could not have furnished the services on the specific dates for which Clear Vue billed the Medicare program. ALJ Decision at 2. Therefore, the ALJ concluded, CMS properly revoked Clear Vue's Medicare enrollment under 42 C.F.R. § 424.535(a)(8). *Id*. First, the ALJ reasoned that CMS had a legitimate basis for revocation because the plain language of the regulation authorizes revocation based on a single improper claim, though "CMS has decided not to enforce the rule so strictly" in stating that "it will not revoke unless the supplier has submitted at least three" such claims. *Id*. at 3 (citing 42 C.F.R. § 424.535(a)(8) and 73 Fed. Reg. 36,448, 36,455 (June 27, 2008)). Next, the ALJ stated that the facts material to determining whether revocation under section 424.535(a)(8) is lawful are: "1) whether the directing physician was out of the country on the dates alleged; and 2) whether the supplier billed Medicare for services it claimed the directing physician provided to specific individuals on those dates." *Id*. (citing *Zille Shah, M.D. and Zille Huma Zaim, M.D., PA*, DAB No. 2688 at 5 (2016); *Mohammad Nawaz, M.D. and Mohammad Zaim, M.D., PA*, DAB No. 2687 at 5 (2016)).[9]

---

[9] The United States Court of Appeals for the Fifth Circuit affirmed the Board's decisions in *Shah* and *Nawaz*. *See Shah v. Azar*, 920 F.3d 987 (5th Cir. 2019), *affirming Mohammad Nawaz, M.D. & Mohammad Zaim, M.D., P.A. v. Price*; *Zille Shah, M.D. & Zille Huma Zaim, M.D., P.A. v. Price*, Nos. 4:16cv386 and 4:16cv387, 2017 WL 2798230 (E.D. Tex. June 28, 2017).

The ALJ made the following findings of undisputed fact: Dr. Barbour was out of the country on the dates of service for as many as 142 claims for which Clear Vue billed Medicare. ALJ Decision at 4-5. In addition, the ALJ found that Clear Vue admitted that Dr. Barbour did not personally furnish the services for which Clear Vue submitted claims to Medicare, where the dates of service fell on dates when Dr. Barbour was out of the country, and Clear Vue admitted that in submitting the claims to Medicare, Clear Vue had represented that Dr. Barbour personally had furnished the services. *Id*. at 5. Further, the ALJ found that Clear Vue admitted to failing to use the proper billing modifiers and to citing incorrect dates of service while arguing that its improper billing amounted to simple billing errors. *See id.* The ALJ summarized her findings of fact and conclusions of law as follows:

> Dr. Barbour was out of the country on the dates [of service] alleged, and Petitioner [Clear Vue] billed the Medicare program for services it claimed she provided to specific individuals on those dates. Thus both of the "facts material" to determining whether CMS properly revoked Petitioner Clear Vue's Medicare enrollment are resolved in CMS's favor, and CMS is entitled to summary judgment.

Id.

The ALJ also rejected Petitioner's other arguments. Applying the Board's reasoning in *John M. Shimko, D.P.M.*, DAB No. 2689 (2016), and *Louis J. Gaefke, D.P.M.*, DAB No. 2554 (2013), the ALJ found that, even if Dr. Barbour provided the services on a few dates but merely misstated the dates of service on Petitioner's claims as Petitioner asserted, CMS came forward with "ample other examples" of Petitioner billing for services that Dr. Barbour did *not* provide, such that Petitioner "does not escape responsibility by showing that its billing agent submitted erroneous claims." *Id*. at 6. As for Petitioner's assertion that some of the services billed were provided by substitute physicians in Dr. Barbour's absence, the ALJ noted that Petitioner conceded that those claims, as submitted, indicated that Dr. Barbour provided them. *Id.* at 6. The ALJ found that, although Petitioner submitted some evidence that other physicians covered for Dr. Barbour while she was out of the country, Petitioner provided no evidence that those physicians furnished the services for which Petitioner submitted claims using Dr. Barbour's name and billing number (on the dates of service identified by First Coast). *Id*. at 6-7. Further, the ALJ found Petitioner alleged but offered no evidence that technicians furnished the services "under general supervision" of physicians pursuant to 42 C.F.R. § 410.32, and Petitioner did not specify which claims were submitted "under general supervision." *Id*. at 7. Finally, the ALJ found that, while Petitioner contended that Dr. Barbour herself furnished some services earlier in the day on the days of her departures from the United States, none of the challenged claims were for services furnished on those dates. *Id*.

The ALJ concluded that, "at best, Petitioner . . . proffered evidence disputing fewer than 40 of the 142 claims." *Id.* The ALJ rejected this evidence, stating:

> To consider those submissions material, I would have to disregard the reasoning of [the Board's decisions in] *Shimko* and *Gaefke*, and I would have to find it permissible for Petitioner to bill Medicare, representing that its owner provided services that were, in fact, provided by others. I therefore do not consider the evidence material.

Id. at 7-8. This appeal followed.

Petitioner's Request for Review

In Petitioner's Request for Board Review and Memorandum of Law (RR), Petitioner disputes several of the ALJ's findings of fact and conclusions of law, which we summarize below.[10] Petitioner contends, generally, that, in rendering her summary judgment decision, the ALJ misinterpreted Petitioner's arguments and mischaracterized Petitioner's evidentiary exhibits.

- Petitioner contends that CMS failed to meet its burden on summary judgment and takes exception to the ALJ's finding (ALJ Decision at 5 ¶ 3) that "both[[11]] of the 'facts material' to determine whether CMS properly revoked Clear Vue's Medicare enrollment [were] resolved in CMS' favor and CMS [was] entitled to summary judgment." RR at 12. Petitioner contends that other facts are material to the outcome of the appeal and that those facts are in dispute because evidence in the administrative record shows that Clear Vue used locum tenens physicians or certified technicians when Dr. Barbour was out of the country. *Id.* at 13.

- Petitioner disputes the ALJ's conclusion that CMS had a legal basis to impose revocation on Clear Vue under 42 C.F.R. § 424.535(a)(8). Specifically, Petitioner disputes the ALJ's conclusion (relying on *Shah* and *Nawaz*) that the "'facts

---

[10] Petitioner's brief to the Board alternates between factual disputes and legal arguments. It includes a lengthy section under the heading "Standard of Review" which commingles factual and legal arguments while contending that CMS failed to meet its burden of proof below on summary judgment, and that Petitioner submitted sufficient evidence to establish material disputes of fact. We have organized this decision to address each of Petitioner's points and arguments in a coherent fashion.

[11] The two "facts material" cited by the ALJ and to which Petitioner refers are "Dr. Barbour was out of the country on the dates alleged, and Petitioner billed the Medicare program for services it claimed she provided to specific individuals on those dates." ALJ Decision at 5.

material' to determine whether CMS properly revoked a supplier's Medicare participation under section 424.535(a)(8) [are] limited to the two facts cited therein." *Id.* at 15 (citing ALJ Decision at 3). Petitioner argues:

> [T]he Board can expand on the "material facts" that it believes are relevant to this case, to determine whether CMS properly revoked Clear Vue's Medicare participation under section 424.535(a)(8). Specifically, we submit that the ALJ should have also take[n] into consideration that the services provided to Clear Vue's patients by *locum tenens* physicians and technicians and done in a manner that is acceptable under Medicare statutes and Medicare Claims Processing Manual . . . are "material facts" that should also be considered in determining whether CMS properly revoked Clear Vue's Medicare provider.

Id. at 15-16.

- Petitioner takes exception to the ALJ's finding (ALJ Decision at 5 ¶ 1) that "Petitioner concedes that, when [Dr. Barbour] submitted bills to the Medicare program, she represented that she had provided the services." *Id.* at 11. Petitioner states that this was not a concession that Dr. Barbour had performed all the services, but rather that she had provided "'some' or 'several' claims." *Id.*

- Petitioner contends that the ALJ incorrectly assumed that Petitioner knowingly allowed other individuals to use Clear Vue's Medicare billing number. *Id.* at 14.

- Petitioner contends that CMS sought to add additional allegedly improper claims to the list of disputed claims supporting revocation when it submitted its summary judgment motion. *Id.* Moreover, Petitioner contends, among the evidence of record as CMS Exs. 4-35 are patient records that support its dispute of CMS's allegations of 142 improper claims. *Id.* at 15.

- Petitioner suggests that the ALJ erred by not following another ALJ decision which was not appealed to the Board. *Id.* at 18.

Standard of Review

We review the ALJ's grant of summary judgment de novo, construing the facts in the light most favorable to Petitioner and giving Petitioner the benefit of all reasonable inferences. *See Livingston Care Ctr.*, DAB No. 1871, at 5 (2003), *aff'd*, *Livingston Care*

Ctr. v. U.S. Dep't of Health & Human Servs., 388 F.3d, 168, 172-73 (6th Cir. 2004). Summary judgment is appropriate when there is no genuine dispute about a fact or facts material to the outcome of the case and the moving party is entitled to judgment as a matter of law. *Id.*; *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986). The party moving for summary judgment has the initial burden of demonstrating that there is no genuine issue of material fact for trial and that it is entitled to judgment as a matter of law. *Celotex*, 477 U.S. at 323. If the moving party carries that burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita Elec. Industrial Co. v. Zenith Radio*, 475 U.S. 574, 587 (1986) (quoting Rule 56(e) of the Federal Rules of Civil Procedure). Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. *See Guidelines — Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's or Supplier's Enrollment in the Medicare Program*, https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/enrollment/index.html (last visited July 18, 2019).

Discussion

The Board determines that the ALJ correctly concluded that CMS established a lawful basis for revocation, and that Petitioner failed to then identify and offer evidence raising a genuine dispute of material fact that causes us to question the soundness of the ALJ's summary judgment decision for CMS. We affirm the ALJ Decision.

A. *The ALJ correctly identified and addressed the dispositive legal issue and correctly concluded that CMS was entitled to summary judgment on that issue.*

The ALJ correctly addressed the dispositive legal question presented: whether CMS properly revoked Petitioner's Medicare enrollment and billing privileges under section 424.535(a)(8). The Board has held that the only issue before an ALJ and the Board in revocation cases is whether CMS has established "a legal basis for its actions." *Letantia Bussell, M.D.*, DAB No. 2196, at 13 (2008). The ALJ concluded that CMS's revocation determination was proper, writing "[CMS . . .] may revoke a supplier's billing privileges if [the supplier] abuses them by submitting a claim or claims for services that could not have been furnished to a specific individual on the date of service, such as 'where the directing physician . . . is not in the state or country when services were furnished.'" ALJ Decision at 2 (citing 42 C.F.R. § 424.535(a)(8)).

Next, the ALJ found that the facts material to the question of whether Petitioner had abused its Medicare billing privileges were: "1) whether the directing physician was out of the country on the dates [of service] alleged; and 2) whether the supplier billed Medicare for services it claimed the directing physician provided to specific individuals on those dates." *Id*. at 3 (citing *Shah* at 5; and *Nawaz* at 5).

Upon reviewing the evidence in a light most favorable to Petitioner, the ALJ found that "over a period of six years, Petitioner Clear Vue billed the Medicare program for services provided while Dr. Barbour was out of the country." ALJ Decision at 4. The ALJ listed twelve specific time frames during which Petitioner had billed Medicare for services provided while Dr. Barbour was out of the country. *Id.* In concluding that the undisputed facts established that a substantial majority of over 140 improper claims in question were for services provided while Dr. Barbour was outside the United States, the ALJ cited CMS Ex. 2 at 4, and Petitioner's Brief at pages 7 and 13. CMS Ex. 2 is Petitioner's reconsideration request. In the request, counsel for Petitioner stated, "Clear Vue agrees that Dr. Barbour traveled out of the country during the time periods" cited by CMS in its revocation notice, but that "[. . .] some of the services provided and billed while Dr. Barbour was out of the country were provided by a substitute practitioner acting in her capacity as a locum tenens physician." CMS Ex. 2, at 4. In Petitioner's Request for Review, Petitioner stated, "Clear Vue has never stated that [Dr. Barbour] provided the services to the beneficiaries herself[.]" RR at 7. Petitioner later explained that "substitute practitioners serving as *locum tenens* and technicians provided services to Dr. Barbour's patients in her absence[.]" *Id.* at 13 (italics in the original). After considering the representations by Petitioner's legal counsel made on Petitioner's behalf, the ALJ correctly found that there was no genuine dispute that Dr. Barbour was out of the country on a majority of the dates of service in question, and that Dr. Barbour had not performed the services on those dates for which Petitioner Clear Vue had billed Medicare with Dr. Barbour's billing number.

The Board has reviewed the ALJ's summary judgment decision and the record evidence de novo, and agrees with the ALJ that CMS has established a legal basis for revocation under section 424.535(a)(8). The record evidence includes the tables attached to the revocation notice that reflect the beneficiaries and dates of service (CMS Ex. 3); the beneficiaries' medical charts (CMS Ex. 4-35); the contractor's records reflecting Dr. Barbour as the sole healthcare provider associated with Clear Vue (CMS Ex. 37); the Zone Program Integrity Contractor investigator's statement (CMS Ex. 38); tables reflecting the corresponding dates of Dr. Barbour's foreign travel with services billed (CMS Ex. 39); the HCFA Program Change Request setting forth "revised levels of physician supervision required for diagnostic tests payable under the Medicare physician fee schedule" (CMS Ex. 40); and PECOS (the internet-based Provider Enrollment, Chain, and Ownership System)[12] billing records for the questioned claims (CMS Ex. 41). These records establish that Dr. Barbour was out of the country and did not render the services for which Petitioner billed Medicare, in more than three instances. Therefore, we agree,

---

[12] PECOS, https://pecos.cms.hhs.gov, (last visited July 18, 2019) is "an internet-based Medicare enrollment system through which providers and suppliers can submit enrollment applications, view, print, and update enrollment information, and track the status of submitted enrollment applications." *UpturnCare Co., d/b/a Accessible Home Health Care*, DAB No. 2632, at 3 n.4 (2015).

in the absence of countervailing evidence from Petitioner, that CMS was entitled to judgment as a matter of law. *See Celotex*, 477 U.S. at 323. In order to overcome CMS's initial showing that the material facts were undisputed, Petitioner needed to "come forward with 'specific facts showing that there is a genuine issue for trial.'" *See Matsushita,* 475 U.S. at 587. Below we explain why Petitioner failed to identify a genuine dispute of material fact that could change the outcome on revocation under section 424.535(a)(8).

B. Petitioner failed to show that there is a genuine issue of material fact.

Petitioner has offered sworn testimony and other evidence to support its argument that a dispute of material fact exists over whether Petitioner abused its Medicare billing privileges. Petitioner argues that it could correctly bill for certain services even in Dr. Barbour's absence, either because some services required only general supervision of technicians or because other services were performed by substitute physicians; that CMS did not intend to invoke its revocation authority for mere clerical mistakes; and that the absence of billing modifiers and other notations which might prove that technicians and substitute physicians furnished the services for which Petitioner billed Medicare amounts to nothing more than clerical mistakes. Petitioner's arguments raise, at best, issues of fact that are peripheral, and ultimately immaterial, to the dispositive legal question – whether CMS lawfully revoked Petitioner's enrollment under section 424.535(a)(8) based on the submittal of multiple claims for services while Dr. Barbour was not in the United States.

1. The written testimony of Dr. Barbour

Dr. Barbour offered her sworn written testimony in affidavit form. CMS Ex. 2 (Attachment E). Dr. Barbour testified that at various times while she was out of the country, other physicians or technicians furnished the services for which Petitioner submitted claims for Medicare payment. She explained that during her absences in 2009 and once in 2015, the services were "provided by a substitute physician acting as locum tenens physician, but the correct modifier, Q6, to indicate the locum tenens had provided the service was mistakenly not included on the claim forms." *Id.* at 1, ¶6. She stated that the substitute physicians were not her or Petitioner's employees, but she did not name them. *Id.* She testified that at other times from 2001 through 2014, while she was out of the country, "a technician employed by me or [Petitioner] provided ancillary ophthalmological testing services, including the technical component of visual fields examination ([HCPCS/CPT code] 92081), fundus photos (92250), determination of refractive state (92015) and scanning computerized ophthalmic diagnostic (92134) on the dates of service at issue." *Id.* at 1, ¶7. She testified that she understood that these services required only her "general supervision, which did not require me to be present

when the testing was furnished" and that she "was available to consult" while out of the country. *Id.* at 1-2, ¶7, 9. She attributes some of Petitioner's improper billing for services furnished while she was out of the country to "transitioning to new software/electronic medical records systems[.]" *Id.* at 2, ¶10. Other errors she attributes to mistakes made by her billing personnel for "several exams on the dates of services the technicians provided diagnostic testing[.]" *Id.* at 2, ¶11.

Dr. Barbour's explanations for many of Petitioner's improper claims fall under the general category of "billing mistakes," which the Board has said do not insulate the provider or supplier from revocation. As the Board stated in *Gaefke*, "the apparently negligent submission of [. . .] claims for services to [. . .] beneficiaries that could not have been delivered as claimed constituted an abuse of Petitioner's billing privileges[.]" DAB No. 2554, at 9. The remaining claims, Dr. Barbour contends, were properly billed for services furnished by technicians in her absence, but still under her general supervision. Even if Dr. Barbour's understanding were correct (and we need not decide here that her understanding was correct), the claims Dr. Barbour does not dispute were errant remain at the center of CMS's revocation action. Under CMS's stated policy, as long as CMS found a pattern of abusive billing (multiple instances, at least three), it could exercise its discretion to revoke a provider or supplier for abusive billing. *See* 73 Fed. Reg. 36,448, 36,455 (June 27, 2008). Accordingly, even if Petitioner could point to a dispute of fact over the services allegedly furnished by technicians, the dispute ultimately would not be material to the outcome of the case because, as the ALJ correctly concluded, it is undisputed that Petitioner submitted multiple claims for services allegedly provided by Dr. Barbour, who could not have furnished them as she was outside the United States. ALJ Decision at 8. Thus Petitioner's evidence, in the form of Dr. Barbour's testimony, fails to raise a genuine dispute of material fact on the legality of revocation under section 424.535(a)(8).

2. The written testimony of substitute physicians

Petitioner offered the written testimony of three physicians (Dr. Ford, Dr. Kelly, and Dr. Haft) who stated that they substituted for Dr. Barbour at times relevant to the claims that are the subject of this appeal. Dr. Ford stated that she "covered for Dr. Barbour" when Dr. Barbour was away in March of 2015. P. Ex. 1. Dr. Haft testified that he had covered for Dr. Barbour on a reciprocal basis between 2008 and 2015 when she was away, supervising her technicians. P. Ex. 2. Dr. Kelly testified that he, too, had covered for Dr. Barbour while she was away, between 2009 and 2015, supervising technicians via telephone and attending to emergency cases. P. Ex. 3. However, Petitioner's records of ophthalmological consultations with 22 Clear Vue patients do not indicate that Drs. Ford, Haft, or Kelly treated them on specific dates that correlate to the dates of claims in question. *See* P. Exs. 4 through 25; ALJ Decision at 6-7.

Moreover, while Petitioner submitted some treatment notes that Petitioner represents as proof that a fourth substitute physician, Dr. Rojas, provided services, Petitioner has not actually correlated that evidence with any of the subject claims as billed for certain dates to show that on such dates Dr. Rojas provided the services while Dr. Barbour was out of the United States. In any case, as the ALJ stated, and we agree, "[v]iewed in the light most favorable to Petitioner, and accepting Petitioner's otherwise unsupported representation, the treatment notes show that Dr. Rojas provided some services for which claims were submitted. . . . At best, however, these account for 35 claims for services provided to 20 patients, leaving a significant number of erroneous claims to justify revocation." ALJ Decision at 7.[13]

Further, Petitioner's evidence does not establish that the claims for payment Petitioner submitted included the correct billing code modifier, Q6, which, if used as it should have been, would have notified CMS that physicians other than Dr. Barbour had furnished the services. *See* CMS Ex. 2, at 4 ("The correct modifier, Q6, to indicate locum tenens providing the service was inadvertently omitted from the claim forms."). As we discussed above, and as the ALJ correctly pointed out, the fact that Petitioner's improper billing may have resulted from clerical errors does not shield it from revocation if CMS discovers, as it had in this case, multiple instances (at least three) of such billing errors. ALJ Decision at 6; *see also* 73 Fed. Reg. 36, 448, 36,455 (June 27, 2008).

Petitioner's evidence raises some factual questions about whether services for which Petitioner billed Medicare were actually provided on some of the dates in question. Those questions, however, are not material to the outcome here because, as the ALJ determined, and we agree, Petitioner "concede[d] that, with a few exceptions, its owner was out of the country and did not provide the services for which Petitioner billed Medicare." ALJ Decision at 8. On that basis, CMS properly revoked Petitioner's Medicare enrollment under section 424.535(a)(8). Thus, even were we to accept the testimony of the three substitute physicians and evidence that one physician, Dr. Rojas, provided some services for which claims were submitted, we have before us no genuine dispute of material fact that precludes summary judgment against Petitioner.

3. The written testimony of Charla Prillaman

Petitioner next offered the sworn declaration of Charla Prillaman, who testified to having "more than 25 years of experience providing coding, compliance and billing services to physician practices." P. Ex. 26, ¶2. According to Ms. Prillaman, "[c]ontrary to the opinion of Jay Cotton, RN [CMS's witness, whose testimony is of record as CMS Ex. 38], when a technician service requires 'general supervision' it does not require that the

[13] Also, as the ALJ noted, Petitioner did not submit the written testimony of Dr. Rojas, whereas Petitioner submitted the written testimony of Drs. Ford, Haft, and Kelly. ALJ Decision at 7.

physician be 'within the office suite or in the room.'" *Id.* at 2 ¶7. Ms. Prillaman stated that she "reviewed Dr. Barbour's medical records that were produced by CMS as CMS Exs. 4-35" and "additional medical records provided by Dr. Barbour." *Id.* at 1 ¶4. However, she did not state what the "additional records provided by Dr. Barbour" were, and she did not identify which claims Petitioner submitted were for services performed by technicians.

Although Petitioner has offered witness testimony attempting to raise a dispute of fact about whether certain services were performed by technicians and not improperly billed, any such dispute is not material to the outcome. Even were we to assume that Petitioner identified the claims that reflect services furnished by technicians under general supervision of substitute physicians, which Petitioner has not done, those claims would still, by Petitioner's own admission, have been improperly billed because Petitioner omitted the Q6 modifier. *See id.* at 2 ¶8. Moreover, we have not been presented evidence on which we can determine that all of Petitioner's medical records contained in CMS Exs. 4 through 35 reflected technician services. There is simply no evidence to support a conclusion that all of the claims at issue were for technician services. Nevertheless, even assuming that some of the claims at issue were for technician services and that those claims were properly billed, as discussed in the ALJ Decision and in our decision, multiple other instances of improper billing remain such that CMS has a legal basis for revocation.

C. Petitioner's other arguments lack merit.

Petitioner makes several other arguments, none of which have merit. Petitioner states that it did not concede that, when Dr. Barbour submitted bills to the Medicare program, she represented that she had provided the services. *See* ALJ Decision at 5. The ALJ's characterization of Petitioner's position as a concession is inconsequential here because CMS holds providers and suppliers responsible for the claims they submit or the claims submitted on their behalf. *See* 73 Fed. Reg. 36, 448, 36,455 (June 27, 2008). Indeed Petitioner itself admits that it submitted the claims without the Q6 modifier (RR at 7), which, if used as it should have been, would have informed CMS that the services were **not** furnished by Dr. Barbour. Petitioner may not have affirmatively indicated through the claims that Dr. Barbour had furnished the services at issue, but by omitting the Q6 modifier, Petitioner effectively represented to CMS that Dr. Barbour had provided the services herself.

Petitioner asserts that the ALJ incorrectly assumed that Petitioner knowingly allowed other individuals to use Clear Vue's Medicare billing number, and suggests that the ALJ erroneously relied on an inapplicable revocation basis. RR at 14. Petitioner misconstrues the ALJ's words on page 6 of her decision. Although there the ALJ cited 42 C.F.R.

§ 424.535(a)(7) and the Board's decision in *Kermit E. White, M.D., & Kermit E. White M.D., P.C.,* DAB No. 2765 (2017), the ALJ stated she was doing so to note that, as a threshold matter, CMS has the authority to revoke a physician's billing privileges if she knowingly allows another individual to use her billing number. There is no question that the only regulatory basis CMS cited for revocation here was section 424.535(a)(8), and the ALJ's rationale clearly reflects a sound analysis of the legality of revocation under that regulation. We see no legal error in the ALJ Decision related to her reference to section 424.535(a)(7).

Petitioner also contends that CMS sought to add to the list of disputed claims supporting revocation when it submitted its summary judgment motion. RR at 14-15. We construe this argument as another attempt to show that there is a genuine dispute of material fact that precludes summary judgment. The attempt fails. The record in this case reflects that CMS based its revocation action on the list of 142 claims attached to its revocation notice. As the ALJ's rationale makes clear, and as we have said in our decision, at bottom, there remain multiple improper claims (and those claims were among the 142 claims of which Petitioner had notice), and they establish a basis for revocation under section 424.535(a)(8). Moreover, Petitioner has not argued or shown that it has been subjected to revocation based on claims for which it received no prior notice, nor has Petitioner argued that it was denied the opportunity to dispute the revocation based on the claims for which CMS gave Petitioner notice.

Petitioner also states that among the patient records submitted as CMS Exs. 4 through 35 were 51 patient records that actually account for many more claims than the number of patient records since one patient record could account for multiple claims. Petitioner suggests that the ALJ should have fully considered, but did not consider, all of that evidence to examine every disputed claim. *Id.* at 15. Having carefully examined all of the record evidence ourselves, we see no basis to question whether the ALJ fully examined all of the record evidence. We find that the ALJ's analysis accurately and succinctly captures what the evidence shows as to the disputed claims. Moreover, regardless of whether each patient record addresses one claim or multiple claims, the important issue is whether the record evidence documents multiple (at least three) improper claims. The ALJ determined that it does, and we agree with her determination.

Finally, Petitioner argues that the ALJ erred by failing "to apply the precedential holding in *Velocity* [*Healthcare Services, LLC*, DAB CR3849 (2015)]", which Petitioner contends reversed a CMS revocation determination under section 424.535(a)(8). RR at 18. However, earlier in its brief, Petitioner acknowledged that ALJ decisions do not bind other ALJs or the Board. *Id.* at 9.

The ALJ who decided Petitioner's appeal was not bound to follow *Velocity*, which was decided by a different ALJ. Moreover, *Velocity* was not appealed to the Board. As the Board has stated,

> [a]n unappealed ALJ decision [does not set] a precedent binding on ALJs or the Board. When the *Board* has not reviewed the ALJ decision, the *Board* has not issued a decision in that case. Regardless of whether an ALJ decision was appealed to the Board, an ALJ decision is not precedential and does not bind the Board, and is relevant in later cases only to the extent its reasoning is on point and persuasive.

Avalon Place Trinity, DAB No. 2819, at 13 (2017) (italics in original) (citing *John M. Shimko, D.P.M.*, DAB No. 2689, at 5 (2016)), *aff'd*, *Avalon Place Trinity v. HHS*, 761 Fed. Appx. 407, No. 17-60781 (5th Cir. Mar. 4, 2019).

Moreover, having considered *Velocity*, we find that the ALJ's reasoning therein does not aid Petitioner. In *Velocity*, a Zone Program Integrity Contractor recommended that the Medicare Administrative Contractor (MAC) revoke Velocity's enrollment pursuant to 42 C.F.R. § 424.535(a)(1), citing Velocity's "noncompliance with requirements of Medicare enrollment." *Velocity* at 1. The MAC revoked Velocity's enrollment. *Id*. However, the MAC cited 42 C.F.R. § 424.535(a)(8) as the basis for revocation, rather than 42 C.F.R. § 424.535(a)(1), which it should have cited if the reason for revocation was "noncompliance with requirements of Medicare enrollment." *Id*. In reversing the revocation determination, the ALJ in *Velocity* concluded that CMS lacked a legal basis to revoke under section 424.535(a)(8), the only basis cited, because "there is no dispute that [Velocity] furnished the services in question."[14] *Id*. at 5. The ALJ also concluded that CMS's "argument that [Velocity] 'was not in compliance with Medicare program requirements' invokes a different subsection of the regulations [that is, section 424.535(a)(1)]." *Id.* at 7. *Velocity* is therefore distinguishable from the instant case, in which revocation under section 424.535(a)(8), the cited basis, **is** substantiated. We conclude that the ALJ who decided Petitioner's appeal committed no error in not relying on *Velocity*.

[14] The prior section 424.535(a)(8) under which Velocity was revoked (similar to the revised regulation under which Petitioner was revoked) authorized CMS to revoke billing privileges for abuse, that is, if the provider or supplier "submits a claim or claims for services that could not have been furnished to a specific individual on the date of service" because, for instance, "the directing physician or beneficiary is not in the State or country when services were furnished . . . ."

Conclusion

For the reasons stated above, the Board affirms the ALJ Decision upholding the revocation of Petitioner's Medicare enrollment and billing privileges for a period of three years.

/s/
Constance B. Tobias

/s/
Susan S. Yim

/s/
Christopher S. Randolph
Presiding Board Member